TABLE 2.1 DEFINITION OF TWO MEDICAL HOME TIERS

Tier 1

All 17 of the Following Requirements (17 Core)

Continuity

1) The practice discusses with patients and presents written information on the role of the medical home that addresses up to 8 areas.

2) The practice establishes written standards on scheduling each patient with a personal clinician for continuity of care and the practice collects data to show that it meets its standards on

Clinical Information Systems

3) The practice uses an electronic data system that includes searchable data such as patient demographics, visit dates and diagnoses (up to 12 specific factors), and the practice uses an electronic or paper-based system to identify clinically important conditions or risk factors among its patient population.

Delivery System Redesign

4) The practice establishes written standards to support patient access, including policies for scheduling visits and responding to telephone calls and electronic communication (up to 9 specific factors).

5) The practice collects data to demonstrate that it meets standards related to appointment scheduling and response times for telephone and electronic communication (up to 5 specific factors).

6) The practice defines roles for physician and non-physician staff and trains staff, with non-physician staff, involved in reminding patients of appointments, executing standing orders and educating patients/families.

7) The practice uses electronic or paper-based tools including medication lists and other tools such as problem lists, or structured templates for notes or preventive services to organize and document clinical information in the medical record.

8) The practice conducts a comprehensive health assessment for all new patients to understand their risks and needs including past medical history, risk factors and preferences for advance care planning (up to 5 specific factors).

9) For three clinically important conditions, the physician and non-physician staff conducts care management using an integrated care plan to set goals, assess progress and address barriers (5 specific factors).

10) For three clinically important conditions, the physician and non-physician staff conduct care management planning ahead of the visit to make sure that information is available and the staff is prepared as well as following up after the visit to make sure that the treatment plan (including medications, tests, referrals) is implemented.

11) The practice identifies appropriate evidence-based guidelines that are used as the basis of care for clinically important conditions.

Patient/Family Engagement

12) The practice supports patient/family self-management through activities such as systematically assessing patient/family-specific communication barriers and preferences, providing self-monitoring tools or personal health record, and providing a written care plan.

13) The practice supports patient/family self-management through providing educational resources, and providing/connecting families to self-management resources.

14) The practice encourages family involvement in all aspects of patient self-management.

Coordination

15) The practice systematically tracks tests and follows up using steps such as making sure that results are available to the clinician, flagging abnormal test results, and following up with patients/families on all abnormal test results (up to 4 specific factors).

16) The practice coordinates referrals designated as critical through steps such as providing the patient and referring physician with the reason for the consultation and pertinent clinical findings, tracking the status of the referral, obtaining a report back from the practitioner, and asking patients about self-referrals and obtaining reports from the practitioner(s).

17) The practice reviews all medications a patient is taking including prescriptions, over the counter medications and herbal therapies/supplements.

TABLE 2.2 DEFINITION OF TWO MEDICAL HOME TIERS

Tier 2

All 19 of the Following Requirements

Continuity

1) The practice discusses with patients and presents written information on the role of the medical home that addresses up to 8 areas.
2) The practice establishes written standards on scheduling each patient with a personal clinician for continuity of care and the practice collects data to show that it meets its standards on continuity.

Clinical Information Systems

3) The practice uses an electronic data system that includes searchable data such as patient demographics, visit dates and diagnoses (up to 12 specific factors), and the practice uses an electronic or paper-based system to identify clinically important conditions or risk factors among its patient population, and the practice has an electronic health record, certified by the Certification Commission on Health Information Technology (C-CHIT), that captures searchable data on clinical information such as blood pressure, lab results or status of preventive services (up to 9 specific areas).

Delivery System Redesign

4) The practice establishes written standards to support patient access, including policies for scheduling visits and responding to telephone calls and electronic communication (up to 9 specific factors).
5) The practice collects data to demonstrate that it meets standards related to appointment scheduling and response times for telephone and electronic communication (up to 5 specific factors).
6) The practice defines roles for physician and non-physician staff and trains staff, with non-physician staff, involved in reminding patients of appointments, executing standing orders and educating patients/families.
7) The practice uses electronic or paper-based tools including medication lists and other tools such as problem lists, or structured templates for notes or preventive services to organize and document clinical information in the medical record.
8) The practice conducts a comprehensive health assessment for all new patients to understand their risks and needs including past medical history, risk factors and preferences for advance care planning (up to 5 specific factors).
9) For three clinically important conditions, the physician and non-physician staff conduct care management using an integrated care plan to set goals, assess progress and address barriers (5 specific factors).
10) For three clinically important conditions, the physician and non-physician staff conduct care management planning ahead of the visit to make sure that information is available and the staff is prepared as well as following up after the visit to make sure that the treatment plan (including medications, tests, referrals) is implemented.
11) The practice identifies appropriate evidence-based guidelines that are used as the basis of care for clinically important conditions.

Patient/Family Engagement

12) The practice supports patient/family self-management through activities such as systematically assessing patient/family-specific communication barriers and preferences, providing self-monitoring tools or personal health record, and providing a written care plan.
13) The practice supports patient/family self-management through providing educational resources, and providing/connecting families to self-management resources.
14) The practice encourages family involvement in all aspects of patient self-management.

Coordination

15) The practice systematically tracks tests and follows up using steps such as making sure that results are available to the clinician, flagging abnormal test results, and following up with patients/families on all abnormal test results (up to 4 specific factors).

16) The practice coordinates referrals designated as critical through steps such as providing the patient and referring physician with the reason for the consultation and pertinent clinical findings, tracking the status of the referral, obtaining a report back from the practitioner, and asking patients about self-referrals and obtaining reports from the practitioner(s).

TABLE 2.12 DEFINITION OF TWO MEDICAL HOME TIERS
Tier 2, Continued

17) The practice reviews all medications a patient is taking including prescriptions, over the counter medications and herbal therapies/supplements.
18) The practice on its own or in conjunction with an external organization has a systematic approach for identifying and coordinating care for patients who receive care in inpatient or outpatient facilities or patients who are transitioning to other care (up to 6 specific factors).
19) The practices reviews post-hospitalization medication lists and reconciles with other medications.

AND 3 of the 9 Additional Requirements

Continuity

(None)

Clinical Information Systems

20) The practice uses an electronic system to write prescriptions which can print or send prescriptions electronically, clinicians in the practice write prescriptions using electronic prescription reference information at the point of care, which includes safety alerts that may be generic or specific to the patient (up to 8 specific factors), and clinicians engage in cost-efficient prescribing by using a prescription writer that has general automatic alerts for generic or is connected to a payer-specific formulary.
21) The practice provides patients/families with access to an interactive Web site that allows electronic communication.
22) The practice provides for patient access to personal health information such as test results or prescription refills or to see elements of their medical record and import elements of their medical record into a personal health record.

Delivery System Redesign

23) The practice measures or receives data on performance such as clinical process, clinical outcomes, service data or patient safety issues, and the practice collects data on patient experience with care, addressing up to 3 areas.
24) The practice reports performance data to physicians.
25) The practice uses performance data to set goals and take action where identified to improve performance.
26) The practice uses electronic information to generate lists of patients and take action to remind patients or clinicians proactively of services needed, such as patients needing clinician review or action or reminders for preventive care, specific tests or follow-up visits (up to 5 specific factors).
27) The practice uses a paper-based or electronic system for reminders at the point of care based on guidelines for preventive services such as screening tests, immunizations, risk assessments and counseling.
28) The practice uses a paper-based or electronic system for reminders at the point of care based on guidelines for chronic care needs.

Patient/Family Engagement

(None)

Coordination

(None)